GRADY MEMORIAL HOSPITAL
CHICKASHA, OKLAHOMA

Scheduled Appointment Information

Your physician ordered sleep study has been scheduled as follows:

Date and Time: _____**AT 8:30 PM**

Location: **2220 Iowa Ave, Chickasha ,OK 73018**

Please arrive at **8:00 pm at Grady Memorial Hospital, check in through the Emergency Room**. After you are checked in, the sleep technician will escort you to the sleep lab.

- **Due to the increased volume of patients if you arrive more than 15 minutes after your scheduled time, the appointment may be given to someone else. If you are running late the night of your study, please contact a technician at 405-779-2201 to hold your spot.**

IMPORTANT: **Patients who require assistance from a caregiver must inform the scheduler prior to appointment so arrangement can be made.**

*** Reminder:** No nap or caffeine after 12 pm the day of your study. Please eat your evening meal at least 2 hours prior to your scheduled test time. Do not consume any Alcohol 24 hours prior to the test

Things to bring with you:

1. The enclosed questionnaire – (please complete prior to arrival)
2. Something loose fitting and comfortable to sleep in, as well as, a robe and slippers.
3. All medications that you are currently taking - (please have them written down prior to arrival)
4. Your insurance card and two forms of identification including a picture I.D.

Things to remember:

1. Questions regarding your medications should be referred to your physician.
2. Please take all of your medications as you normally do. If you use a sleep aide, we ask that you bring it with you and inform the technician before you take it.
3. Your hair **must** be clean and free of gels and hair spray materials.
4. We have pillows; however, please feel free to bring your own to add to your comfort.
5. Bring an overnight bag with the items you would normally use for an overnight stay.
6. Smoking materials, tobacco, and firearms are prohibited in our facility.
7. Please complete all smoking prior to coming up to the sleep disorders center.
8. You should contact our office, and speak directly to our staff, if you have any of the following on the day you are scheduled for your sleep study: Flu, diarrhea, fever, severe nasal congestion, or migraine headache. If you feel you need to reschedule your sleep study, please contact our staff at **405-949-0060.**

Insurance & Financial Information:

If you have any questions regarding your financial responsibility please feel free to call Grady Memorial Hospital at **405-779-2201.** You will be responsible for the actual contracted amount if the claim is not paid in full. We urge you to contact your insurance provider member services to verify the information above.

Any scheduling questions should be directed to Sleep Solutions, M-F 8-5, at 405-949-0060 or 866-748-4350. Our patient care coordinator will be happy to answer any questions you may have.

Information on Sleep Disorders

Are you getting a good night's sleep? Sleep disorders cause more than just sleepiness – a lack of restorative rest can cause accidents on the job and on the road; affect your relationships, health, and mental capability; and make you feel generally "disconnected" to the world around you. .

Sleep disorder symptoms

Getting a good night's sleep is essential for feeling refreshed and alert during the day. Sleep disorders left untreated can even be hazardous to your health. Luckily, through proper testing, diagnosis and care, sleep disorders can be managed and overcome.

Particular behaviors during normal daytime activities are telltale signs of sleep deprivation. If you are experiencing one or more of the following symptoms during the day, you may not be getting enough restful sleep at night, and you may even have a sleep disorder.

Do you . . .

- feel irritable or sleepy during the day?
- have difficulty staying awake when sitting still, such as when watching television or reading?
- fall asleep sometimes while driving?
- have difficulty paying attention or concentrating at work, school, or home?
- perform below your potential in work, school, or sports?
- often get told by others that you look tired?
- have difficulty with your memory?
- react slowly?
- have emotional outbursts?
- feel like taking a nap almost every day?
- require caffeinated beverages to keep yourself going?

Common types of sleep disorders

In order to get a proper diagnosis, it's important to understand the symptoms and causes of the most common forms of sleep problems - **Sleep Apnea, Insomnia, RLS, and Narcolepsy.**

Sleep Apnea Sleep Disorder

Sleep apnea is a common disorder that can be very serious, and even life-threatening. In sleep apnea, your breathing stops or gets very shallow while you are sleeping. Each pause in breathing typically lasts 10 to 20 seconds or more. These pauses can occur 20 to 30 times or more an hour.

The most common type of sleep apnea is **obstructive sleep apnea.** During sleep, enough air cannot flow into your lungs through your mouth and nose, even though you try to breathe. When this happens, the amount of oxygen in your blood may drop. Normal breaths then start again with a loud snort or choking sound.

Symptoms can be quite scary - frequent waking episodes at night, usually accompanied by a feeling of "choking" or gasping for air. Significant others or roommates of those with sleep apnea often report hearing gasping, gagging, or choking sounds from their partners. The severity of this disorder makes treatment essential. Treatment may include behavioral changes, a CPAP/BiPap machine, and in some cases, surgery.

Insomnia

Insomnia is a significant lack of high-quality sleep. It can be short-term or chronic. Insomnia may be caused by stress, a change in time zones or sleep schedule, poor bedtime habits, or an underlying medical or psychiatric condition.

Symptoms include:

- Difficulty falling asleep despite being tired
- Requiring sleeping pills or alcohol to fall asleep
- Awakening frequently during the night or lying awake in the middle of the night
- Awakening too early in the morning despite not feeling refreshed
- Daytime drowsiness, fatigue, and irritability

Restless Legs Syndrome (RLS)

Restless legs syndrome (RLS) is a sensory disorder causing an almost irresistible urge to move the legs. The urge to move the legs is usually due to uncomfortable, tingly, or creeping sensations that occur when at rest. Movement eases the feelings, but only for a while. You may also notice small, jerky movements of the toes, feet, and legs as you are trying to fall asleep.

Narcolepsy

Narcolepsy is a disorder that causes a person to have difficulty staying awake. Narcolepsy can cause a person to suddenly fall asleep during the day. These “sleep attacks” occur even after getting enough sleep at night. The unusual sleep pattern that people with narcolepsy have can affect their schooling, work, and social life.
Falling asleep during activities like walking, driving, cooking, or talking can have dangerous results, both professionally and personally.

Symptoms include:

- Intermittent, uncontrollable episodes of falling asleep during the daytime
- Excessive daytime sleepiness
- Sudden, short-lived loss of muscle control during emotional situations (cataplexy)

Common tests for diagnosing sleep disorders

Epworth Sleepiness Scale- This sleep questionnaire asks you to rank whether certain situations make you sleepy and, if so, how sleepy.

Overnight sleep study- is a test that measures the electrical activity of your brain (electroencephalogram) and heart (electrocardiogram), and the movement of your muscles (electromyogram) and eyes (electro-oculogram), and usually requires an overnight stay at a sleep clinic for observation purposes.

Once you arrive to our facility, a team of sleep specialists will use the latest technology to monitor you while you sleep. You will be given a private room, where a technician will attach a variety of monitoring devices to your body once you are ready for bed. A sleep specialist will observe your sleep patterns using these devices, which monitor brain waves, heart rate, rapid eye movements, and more.

The next morning, the technician will remove all the monitoring devices, and you will be able to go straight to work or on to your daily activities. The sleep specialists will analyze the results from your sleep study and send your referring physician the results where he/she will go over and design a treatment program if necessary. If treatment of sleep apnea is necessary, you will be sent to a DME company for CPAP setup.

GRADY MEMORIAL HOSPITAL
CHICKASHA, OKLAHOMA

PLACE LABEL HERE

SLEEP STUDY MEDICAL HISTORY

Patient Name: _____

Height: _____ Weight: _____ Age: _____

Symptoms of Sleep Disturbances: (check those that apply)

☐ Witnessed apnea	☐ Shortness of breath	☐ Sleep-Walking	☐ Chronic fatigue
☐ Post UPP	☐ Nightmares	☐ Asthma	☐ Narcolepsy
☐ Snoring	☐ Obesity	☐ Elongated palate	☐ Cataplexy
☐ Restless legs	☐ Bedwetting	☐ Excessive sleepiness	☐ Insomnia
☐ Nocturnal choking	☐ Nasal obstruction	☐ p.m. alcohol	☐ Claustrophobia
☐ Leg/body jerks	☐ Sleep terrors	☐ Chronic Pain	
☐ Fitful sleep	☐ GI reflux/heartburn	☐ Periodic leg movement	
☐ REM Behavior	☐ Sleep attacks	☐ Violent activity during sleep	
☐ Depression	☐ Frequent awakenings		

Pertinent Medical History: (check those that apply)

☐ High Blood pressure	☐ Head injury	☐ Heart attack
☐ COPD/Emphysema	☐ Neuromuscular disease	☐ Memory loss
☐ s/p stroke	☐ Seizures	☐ Neuromuscular Disease
☐ Cardiovascular disease	☐ Premature birth	☐ Parkinson's Disease
☐ Diabetes	☐ Thyroid disease	☐ Mood disorder
☐ Kidney failure	☐ Broken nose	☐ Fibromyalgia
☐ Cerebral Palsy	☐ Oxygen: LPM____	☐ Other:_____
☐ Head injury	☐ History of Motor Vehicle Accident	

Surgeries: (check those that apply)

☐tonsils ☐adenoids ☐UPPP ☐deviated septum ☐nasal polyp ☐laser
☐tracheotomy ☐upper or lower ☐jaw reconstruction

Previous Sleep Study:

☐No ☐Yes When and where:_____
(If previous sleep study, please include a copy of this report.)

Current Treatment of Sleep Apnea:

☐CPAP Pressure_____ ☐ Bi-Level Pressure_____ ☐Oxygen Liters_____

Medications:_____

_____

_____

*Revised 7/12/2011

GRADY MEMORIAL HOSPITAL
CHICKASHA, OKLAHOMA

SLEEP QUESTIONNAIRE

Patient Name: _____ Date: _____

Date of Birth: _____ Sex: (circle one) M F Height: _____ Weight: ____

Referring Physician: _____ Primary Care Physician: _____

Welcome to our sleep clinic. The following questions will help us understand more about you and your possible symptoms. Please answer the questions as frankly and accurately as possible as they relate to the last 12 months. Do not leave any question unanswered.

PLACE LABEL HERE

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

Main Complaint (Please describe):
_____

How long have you had this problem? About _____ years

Have you ever seen a physician for this problem? Yes __ No ___

Have you ever had a sleep study before? Yes ___ No ___

If yes, when and where: _____

Do you have a CPAP or BiPAP machine? Yes ___ No ___ How much do you use the machine? _____

Do you use O_2 at home? Yes ___ No ___ Night Time O_2 use: Yes ___ No ___

What is your normal bedtime? (When you try to go to sleep, although you may not actually fall asleep until later)
_____

How long does it usually take you to fall asleep? _____

Do you awaken often during the night? Yes ___ No ___ How many times: _____
If yes, why? _____

What time do you get up in the morning? _____ Do you feel refreshed? _____

Do you usually nap during the day? Yes ___ No ___

Do you work different shifts? Yes ___ No ___ What shift? _____

Circle the appropriate responses

I have high blood pressure:	Yes / No	I have diabetes:	Yes / No
I have an irregular heartbeat:	Yes / No	I have asthma:	Yes / No
I have had a stroke or TIA:	Yes / No	I have heartburn at night:	Yes / No
I have history of congestive heart failure:	Yes / No	I have seizures:	Yes / No
I have had a heart attack:	Yes / No	I have COPD:	Yes / No

Please answer the following questions using this scale (consult bed partner):
0 = Never 1 = Rarely 2 = Sometimes 3 = Often 4 = Frequently 5 = Always

0 1 2 3 4 5	I have been told that I snore.
0 1 2 3 4 5	Others cannot sleep in the same room because I snore loudly.
0 1 2 3 4 5	I have been told that I stop breathing while asleep.
0 1 2 3 4 5	I do not feel refreshed when I awaken.
0 1 2 3 4 5	I have to take naps during the day.
0 1 2 3 4 5	I have problems with my performance at work because of fatigue and tiredness.
0 1 2 3 4 5	I sometimes fall asleep at inappropriate times.
0 1 2 3 4 5	I fall asleep at work.
0 1 2 3 4 5	I fall asleep at meetings.
0 1 2 3 4 5	I have fallen asleep while driving.
0 1 2 3 4 5	I awaken with headaches.
0 1 2 3 4 5	I sweat at night.
0 1 2 3 4 5	I have awakened during the night choking.
0 1 2 3 4 5	I have trouble getting to sleep at night.
0 1 2 3 4 5	I have trouble staying asleep at night.
0 1 2 3 4 5	I have been told I kick during my sleep.
0 1 2 3 4 5	I have an aching or crawling sensation in my legs in the evening.
0 1 2 3 4 5	The aching or crawling sensation in my legs worsens if I keep my legs still.
0 1 2 3 4 5	The unpleasant sensations in my legs improve with activity.
0 1 2 3 4 5	I eat in my sleep.
0 1 2 3 4 5	I have been told I walk in my sleep.
0 1 2 3 4 5	I have been told I talk in my sleep.
0 1 2 3 4 5	When I laugh or get angry, I feel like I am going limp. (getting weak)
0 1 2 3 4 5	When I am falling asleep or awakening, I am paralyzed and unable to move.
0 1 2 3 4 5	I have vivid dreams or hallucinations as I go to sleep or wake up.
0 1 2 3 4 5	I have been told I act out my dreams.
0 1 2 3 4 5	I have nightmares.

PLACE LABEL HERE

GRADY MEMORIAL HOSPITAL
CHICKASHA, OKLAHOMA

How much caffeine do you consume daily? Coffee (cups) _____ Cola/Tea: _____

Do you drink caffeine in the evening? Yes ___ No __ Do you drink alcohol before bedtime? Yes ___ No ___

Kind and Amount:

_____

PLACE LABEL HERE

Serious Medical Problems and Surgeries (with dates)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List all medications you are currently using:

Name of Medication	Dose & Frequency	Last time medication was taken?	Name of Medication	Dose & Frequency	Last time medication was taken

GRADY MEMORIAL HOSPITAL
CHICKASHA, OKLAHOMA

Name: _____
Date: _____

EPWORTH SLEEPINESS SCALE

How likely are you to fall asleep or doze in the circumstances listed below? When rating these situations, give the highest consideration to recent events. If you have never experienced one of these situations, estimate how you might have reacted.

0 = no chance

1 = slight chance
2 = moderate chance
3 = high chance

SITUATION:

Sitting and reading	_____
Watching television	_____
Sitting inactive in a public place (i.e. theater or meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking quietly to someone	_____
Sitting quietly after lunch without alcohol	_____
In a car while stopped for a few minutes in traffic	_____
TOTAL:	**_____**

PLACE LABEL HERE

GRADY MEMORIAL HOSPITAL
CHICKASHA, OKLAHOMA

Patient Information:

Patient Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Ht_____ LBS_____ Referring Physician_____

Primary Care Physician_____ Phone Number _____

SS#: _____ Gender: ☐ Male ☐ Female
Marital Status ☐S ☐M ☐D ☐W

Email address: _____

Insurance Information: **Please provide our office with a copy of your insurance card.**

Primary Insurance Carrier:_____ Phone: _____

ID #: _____Policy Group #: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Secondary Insurance Carrier:_____ Phone: _____

ID #: _____Policy Group #: _____

Policy Holder: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Employment Information:

Employer_____ Work Ph#: _____

If the patient is a minor, please list guardian information:

Guardian: _____ Phone #: _____

Third Party Billing:

Is your injury work related? ☐**Yes** ☐**No**

Is this injury due to an accident? ☐**Yes** ☐**No**

If your injury is MVA related, have you obtained an accident report? ☐**Yes** ☐**No**

Injury date or Date of Occurrence:_____.

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____

Signature: _____ Date: _____

Revised 3/14/2014